# MEDICAID

MONTANA MEDICAID CERTIFICATE OF MEDICAL NECESSITY

DURABLE MEDICAL EQUIPMENT AND SUPPLIES (Rev., May 07)

## OXYGEN, SUPPLIES & EQUIPMENT

Certification: Type/Date
INITIAL ___/___/___ REVISED ___/___/___ RECERT ___/___/___

| PATIENT NAME, ADDRESS, TELEPHONE NUMBER, DATE OF BIRTH | PHYSICIAN NAME, ADDRESS, TELEPHONE NUMBER |
|---|---|
| MEDICAID I.D. NUMBER: | NPI NUMBER: |

DIAGNOSIS: HEIGHT: WEIGHT:

PROGNOSIS: EST. LENGTH OF NEED (# OF MONTHS): 1-99 (99 = LIFETIME)

1. Current residence: (circle the appropriate) Home, Nursing Home, Hospital Rehab Unit, Institution, Group Home, Other _____

2. Enter the result of the most recent test taken **on or before** the certification date listed above. **(THIS INFORMATION MAY NOT BE COMPLETED BY THE SUPPLIER)**

Arterial blood gas PO2 _____mm Hg Oxygen saturation _____ % Name/Address of physician/provider performing test:

2a. Was this test performed **either** with the patient in a chronic stable state as an outpatient **or** within **two** days prior to discharge from an inpatient facility to home? Y / N

2b. Circle patients condition of the test: (1) At Rest (2) During Exercise (3) During Sleep

2c. Was this test performed while the patient was on oxygen? Y / N

3. What is the oxygen flow rate ordered for this patient in liters per minute? _____ LPM _____ Hours per day

**IF PO2 = 56-59 OR OXYGEN SATURATION = 89%, AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE MET.**

4. Does the patient have dependent edema due to congestive heart failure? Y / N

5. Does the patient have corpulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement? Y / N

6. Does the patient have a hematocrit greater than 56%? Y / N

7. Narrative description of **ALL** items, accessories, options and method of delivery: (If additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included on the attached document.)

Y / N ADDITIONAL ATTACHMENTS ARE INCLUDED

I certify that I am the treating physician identified in this form. I certify that the medical necessity information contained in this document and its attachments are true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE DATE / / (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

MONTANA
Department of Public Health & Human Services